

Binational Notification

Fax to: (619) 692-8020

Referring

Jurisdiction _____ Date sent ____/____/____

Contact person: _____
City County State Phone () _____ FAX () _____

☐ Verified case State reporting to CDC: _____ RVCT# _____ ☐ Not reported INS A# _____
☐ Suspect case ☐ Close contact ☐ Immunocompromised ☐ Convertor (LTBI) ☐ Source case investigation

Patient name _____ Sex ☐ M ☐ F
Paternal Last Maternal Last First Middle

AKA: _____ Date of birth: ____/____/____

New address: _____
Number/Street/Apt. Colonia

City/Municipio/State/ZipCode

New telephone () _____ Date of expected arrival ____/____/____

New health provider ☐ Unknown ☐ Known (name, address, phone) _____

Emergency contact in US: Name _____ Phone () _____

Relationship: _____

Emergency contact in Mexico: Name _____ Phone () _____

Address: _____

Relationship: _____ Telephone located at: _____
Residence, public phone, workplace, etc.**Clinical information for:** ☐ this referred case/suspect ☐ index case for this contact ☐ this contact ☐ not applicableSite(s) of disease: ☐ Pulmonary ☐ Other(s) specify all _____

DIAGNOSTIC AND FOLLOW-UP LABORATORY TESTS

Date of Collection	Specimen type	Smear	Culture	Susceptibility	Chest X-ray	Skin Test
Date	Other tests	Result				

Medications ☐ this referred case/suspect ☐ this referred contact/LTBI

Drug	Dose	Start date	Stop date

Planned completion date ____/____/____

DOT ☐ No ☐ Yes: start date ____/____/____☐ Daily ☐ 1x W ☐ 2x W ☐ 3x W

Last DOT Date ____/____/____

Adherence problems/significant drug side effects:

Patient given _____ days of medication

Comments: _____

HHSA:DC-50 (8/02)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY

